two ounces of chloroform was used. The puerperal period was uneventful. Within a week from this time the patient developed signs of acute diabetes, and died of diabetic coma three weeks later in spite of vigorous treatment. Since seeing this case in the material of 468 obstetrical cases the writer had four in which there was glycosuria. It is true that lactose and glucose may appear in the urine, with no more significance than demonstrating a normal stimulation of the mammary glands, as they are prepared for lactation, and these substances will often disappear from the urine after lactation is established. In other cases, however, this does not happen and the excretion of sugar in any form or amount shows derangement in metabolism, and when to this disturbance in metabolism a pregnancy is added the condition becomes greatly complicated. There can be no doubt but that the finding of the reducing sugar in the urine of a pregnant woman is a serious matter. Lactosuria is unimportant, but when the patient's urine reduces the copper hydroxide in a test solution the fullest test should be made to determine whether lactosuria is a real condition or not. If there is glycosuria true diabetes may be about to manifest itself or may be already present. Although the sugar may disappear from the urine during pregnancy the patient should be kept under observation afterward. Diet should be carefully regulated, and if the patient comes into labor and requires an operation the choice of an anesthetic is a critical one, and attention should be given to lessening the shock of delivery, and thus delaying the formation of important changes in the organism of the patient. When the regulation of diet does control glycosuria the diagnosis of true diabetes becomes very important. While the frequent examination of the urine is useful and thus furnishes the only means of arriving at definite conclusions by estimating the sugar in the blood with a proper calorimeter the method is simple. Whenever sugar appears in the urine the presence or absence of hyperglycemia should be determined. It may be difficult to induce a patient to use ingestion tests of the carbohydrate.

Pregnancy Complicated by Ileus.—HANSEN (*Ugesk. f. Læger*, 1919, lxxxi, 356) has studied the literature of this subject and has collected the reports of 102 cases of ileus complicating pregnancy, of which 57 proved fatal. Operation was done in 64 cases, with a mortality of 45 per cent. and 38 cases were treated without operation, with a mortality of 71 per cent. This condition is usually caused by the formation of adhesions in the abdomen following some previous operation. The pressure of the pregnant uterus on the bowel brings about this complication in a few cases only. There is a difference of opinion concern-in the wisdom of emptying the pregnant uterus in an operation for ileus. In a series of 33 cases reported by one author the abdominal operation was followed by abortion in 24, and this writer recommends the emptying of the uterus by vaginal Cesarean section. Hansen records two of his own cases: The first was that of a multipara, aged thirty-seven years, whose last child had been born thirteen years previously. Since then she had been operated upon for ectopic gestation. Shortly after her last period she had violent abdominal pain. Other symptoms of intestinal occlusion developed, and she was brought to the hospital. At operation a thick, fibrous band was found which was strangulating the small intestine, and was excised. The patient was discharged well a month later and gave birth spontaneously at full term. The second

case was that of a woman, aged twenty-five years, who five years previously had appendicitis and operation. She was six months advanced in her last pregnancy and she was brought to the hospital with symptoms of intestinal obstruction. When the abdomen was opened there was found a fibrous band passing over the small intestine near the ileocecal valve and the transverse colon, and over this band the small intestine had become kinked. The band was tied and removed. The patient made an uneventful recovery, went to full term and gave birth spontaneously. In both of these patients the uterus was left undisturbed.

Toxemia of Pregnancy Treated by Standard Methods.—MOSHER (*Jour. Missouri Med. Assn.*, 1919, p. 1669) describes his experience in forty-four pregnant women suffering from various degrees of toxemia. A considerable number of these cases occurred in a comparatively short time. When an effort is made to account for this it is found that the season of the year was unfavorable, as there were extreme changes in temperature and moisture, and that at this time the people of the United States were subjected to great excitement through the development of the recent war. All patients are examined with a view to detecting the signs of threatened toxemia. Blood-pressure is taken, eye symptoms are noted, the urine is examined and the teeth and tonsils are inspected as possible foci of infection. Clinically speaking the writer believes that eclampsia results from the failure of elimination of toxins. In the early portion of pregnancy he believes these toxins are formed in the placenta, while later they arise from the excretions of the fetus. Acute infections of various sorts predispose to toxemia through the additional burden thrown upon the pregnant woman. Asphyxia resulting from pressure, congestion, decrease in the natural oxygenation of the woman's blood, due to interference with the expansion of the lungs and the action of the heart, may also predispose to toxemia. Whenever eclamptic convulsions develop some focus of infection will be found. In prophylactic treatment the writer believes that a diet of non-irritating food is of primary importance. The action of the bowels, kidneys and skin must be stimulated and the intake and output of fluid should be carefully observed and recorded in a daily report. Care should be taken to eradicate foci of infection in the tonsils, teeth, kidneys and bowels. Deep breathing in fresh air and stimulation of the general circulation are important. The free giving of alkaline salts and food to prevent acidosis is of value. Should blood-pressure be high, veratrum viride may be given to reduce pressure, lessen the pulse-rate and aid in the action of the skin. When a patient grows worse under such treatment the uterus must be emptied. This should be done in the least irritating way, and should be carried out promptly so soon as prophylactic treatment fails. The prompt improvement of the patient after this operation is a fact familiar to all. Ether anesthesia is employed, as this is the only safe anesthetic for use in these cases. The writer's method consists in preliminary gradual dilatation by solid dilators up to No. 20 and then introducing a Voorhees bag No. 4 if at term. After the dilatation has reached a point when vaginal delivery can be accomplished without serious laceration the bag is removed and the patient advised to deliver herself if she can do so. If spontaneous labor fails she is delivered by forceps. Moderate hemorrhage from the uterus is encountered.